STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152653	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CITY DIALYSIS	**3233 EAST COLISEUM BLVD FORT WAYNE, IN 46805**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS This was a federal ESRD [CORE] recertification survey. Survey Dates: October 7, 8, 13, 14, and 15, 2015 Facility #: 012876 CCN #: 152653 Survey Census: In-Center: 106 Total: 106 Sample: RR: 10 Total: 10 Summit City Dialysis is in compliance with the Conditions for Coverage 42 CFR Part 494 for End-Stage Renal Disease Facilities. QR: KH, R.N.	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE